Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: MICHAEL C. MAIER 7401 S. MAIN HOUSTON, TX. 77030	MFDR Tracking #: M4-10-0601-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Box #: NEW HAMPSHIRE INS. CO. REP. BOX # 19	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "carrier is not paying according to the fee schedule…."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $11.78
3. CMS 1500
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…*Coventry issued a revised EOR indicating that no additional payment was recommended…."*

Principle Documentation:

1. Response to DWC 60
2. EOB

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
4-7-09	20610	45,100,113-001,A1,942-003,W1,663	1, 2, 3, & 4	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled *Medical Fee Guideline for Professional Services* effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. This service was denied/reduced by the Respondent with reason codes: "45" (charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement), "100" (any network reduction is in accordance with the network referenced above), "113-001" (network import re-pricing/contracted provider), "A1" (claim/service denied…."), "942-003" (body part mismatch), "W1" (workers compensation state fee schedule adjustment), and "663" (reimbursement has been calculated according to state fee schedule guidelines).

2. A review of the EOBs and of the Disputed Table identify that the Requestor was paid $85.99 for the above disputed CPT code signifying that there is no dispute on this claim. The Requestor submits this MDR stating that the amount paid was not per the MAR (maximum allowable reimbursement) and they are entitled to an additional amount of $11.78. The calculation of the MAR is listed below and in accordance with Rule 134.203 (b) and (c) (1), the Requestor was paid correctly and no additional monies are owed.
   - 20610: $67.38 divided by 36.0666=1.868 x $46.03= $85.99

3. A review of the EOBs identify that the 'network reduction' column is $0.00 signifying that there was no contract reduction applied; therefore, the Division's payment recommendation is made in accordance with the MAR.

4. Per review of Box 32 on the CMS-1500, zip code 77478 is located in Ft. Bend County. The maximum reimbursement amount under Rule 134.203 (b) is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.203
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the service involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.